MARYLAND STATE DEPARTMENT OF EDUCATION
Division of Special Education/ Early Intervention Services

MARYLAND HEARING AID LOAN BANK
HEARING AID LOAN APPLICATION FORM

The purpose of this program is to provide temporary hearing aids for children with hearing loss **under the age of 3** while they are waiting to receive their personal amplification devices. Please contact the **Hearing Aid Loan Bank at 410-767-0739 (voicemail accessible),** if you have any questions.

Please complete Parts A-D of this application and return to:
Maryland State Department of Education
Student Achievement & Professional Development, 9th Floor
Baltimore, Maryland 21201
ATTN: Nicole Bradley
Phone: (410) 767-0244 Fax: (410) 333-8165

The information contained on this form will be kept confidential.

PART A

Referring Audiologist Information

Audiologist Name: _____

MD Audiology License #_____

Mailing Address: _____

_____

Phone Number: _____Fax Number: _____

Child's Information

Name: _____Date of Birth: _____

Parent/Legal Guardian's Name: _____

Mailing Address: _____

_____

Phone Number: _____

PART B

To be completed by the referring audiologist

In order for this request to be processed, a copy of any audiologic testing, medical clearance from the child's ENT, and an agreement form signed by the parent or legal guardian must be provided with this application. Please make copies or fax, as this paperwork will not be returned.

Was this child referred to you based upon failure of the Universal Newborn Hearing Screening protocol? Yes____ No____ If yes, from which hospital _____

What is the configuration and degree of hearing loss?

_____

_____

_____

_____

Is this a binaural or monaural fitting? _____

Please indicate the make and model of hearing aid that you would recommend for this child, numbering preferences 1-3. While we cannot guarantee the exact make and model, please be assured that every attempt will be made to match your request.

1 _____2 _____

3_____

Please specify color of the hearing aid needed: _____ Please note that every attempt will be made to provide the recommended color.

The hearing aid(s) will be sent to the requesting audiologist within 3 days of receiving the application and required documentation. The hearing aid will be selected and sent by the Hearing Aid Loan Bank Director based on the information received.

_____ _____

Audiologist Signature Date

PART C

To be completed by the parent or legal guardian

1. Please describe why you cannot provide immediate access to hearing aids for your child.

   _____

   _____

   _____

   _____

2. Do you currently have insurance coverage to secure permanent hearing aids for your child? If yes, have you contacted your insurance company to apply for hearing aids? Please indicate the insurance company name, and the status of your contact.

   _____

   _____

3. Are you currently eligible for Medical Assistance? If yes, have you contacted Medical Assistance to apply for hearing aids?

   _____

   _____

4. Do you need information regarding resources to secure permanent hearing aids?

   _____

   _____ _____
   Signature of Parent/Legal Guardian Date

   Address _____ Phone_____

   _____

PART D

HEARING AID LOAN AGREEMENT

_____I AGREE THAT MY CHILD WILL RECEIVE (A) LOANED HEARING AID(S) FROM THE MARYLAND STATE DEPARTMENT OF EDUCATION, DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES.

_____I AGREE TO PROVIDE A BRIEF STATEMENT INDICATING THE REASON ASSISTANCE FROM THE LOAN BANK IS REQUESTED.

_____I AGREE THAT IT IS MY RESPONSIBILITY TO MAINTAIN AND CARE FOR THE HEARING AID(S) AND THAT I WILL BE RESPONSIBLE FOR ANY LOSS OR DAMAGE NOT COVERED BY THE HEARING AID WARRANTY UP TO $100.00. THIS EXCLUDES NORMAL WEAR AND TEAR.

_____I AGREE THAT MY CHILD WILL HAVE USE OF THIS/THESE HEARING AID(S) FOR UP TO 6 MONTHS. IF MY CHILD HAS NOT RECEIVED HIS/HER PERSONAL AMPLIFICATION WITHIN THAT TIME, I MAY EXTEND THE LOAN PERIOD BY 3-MONTHS, BY COMPLETING AN EXTENSION AGREEMENT.

_____ I AGREE TO SEEK PERMANENT HEARING AID(S) FOR MY CHILD.

_____I AGREE THAT WHEN MY CHILD RECEIVES HIS/HER PERSONAL AMPLIFICATION, I WILL RETURN THE LOANED HEARING AID(S) TO MY CHILD'S AUDIOLOGIST, TO BE RETURNED TO THE LOAN BANK.

_____ _____
Parent/Legal Guardian Signature Date